TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Forest Park Medical Center

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-15-3846-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The payment rendered does not appear to be paid in accordance with the Texas Department of Insurance Medial Fee Guidelines."

Amount in Dispute: $39,431.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund timely and accurately reimbursed the provider according to rule §134.403 Outpatient Hospital Fee Guidelines."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2014	Outpatient Hospital Services	$39,431.78	$7,747.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is for outpatient surgical services performed in an acute care facility. The applicable rule is 28 Texas Administrative Code 134.403 (f) which states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
>
> (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for

Review of the submitted medical bill did not find a separate request for implantables. Therefore, the services in dispute will be calculated as follows:

- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 36415 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85027 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. The provider billed this procedure code with 2 units; however, review of the submitted documentation finds that only 1 unit is supported. Therefore, only 1 unit can be considered for payment. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $4,259.01. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,555.41. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $2,430.71. The non-labor related portion is 40% of the APC rate or $1,703.60. The sum of the labor and non-labor related amounts is $4,134.31. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when

the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2014 Default CCR as 0.197. This ratio multiplied by the billed charge of $19,000.00 yields a cost of $3,743.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $4,134.31 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $11,488.57. The allocated portion of packaged costs is $11,488.57. This amount added to the service cost yields a total cost of $15,231.57. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $7,996.53. 50% of this amount is $3,998.27. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $8,132.58. This amount multiplied by 200% yields a MAR of $16,265.15.

- Procedure code 29826 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

2. The total allowable reimbursement for the services in dispute is $16,265.15. This amount less the amount previously paid by the insurance carrier of $8,518.02 leaves an amount due to the requestor of $7,747.13. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,747.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,747.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September 1, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.